

# ***The Interagency State Council on Black and Minority Health 2013 Annual Report***



Presented by  
The Interagency State Council on Black and Minority Health  
Members

November 1, 2013

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# The Interagency State Council on Black and Minority Health

IC 16-46-6

Chairman: James Garrett, FSSA

Vice-Chairman: Teri Cardwell, IMHC

Governor: Mike Pence

Lt. Governor: Sue Ellspermann

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11/1/13

The Interagency State Council on Black and Minority Health was created to increase awareness of the significance of health disparities, their impact on the state, and the actions necessary to improve health outcomes for racial, ethnic, and underserved population. The Interagency State Council on Black and Minority Health seeks to establish and maintain collaboration with institutions and community based organizations to focus on improving the health of racial and ethnic minorities in Indiana.

Through collaborations with local and statewide community health partners, the interagency council promotes health initiatives and health events that enhance opportunities for underserved population to close the health disparities gap. Improving health and healthcare outcomes for racial, ethnic, and underserved populations is the objective of the interagency council.

This report highlights the state-wide effort and initiatives of many of the community health partners to improve health literacy, improve cultural and linguistic competency and the diversity of the health relate workforce, and share experiences that improve the health of Black and minority communities.

The interagency council hopes that the legislative body will view this annual report as informative and helpful in addressing health related issues. This report also may serve as a resource guide to address health disparities and share initiatives that have positively impacted the health of Black and Minority Hoosiers.

Sincerely,

A handwritten signature in black ink, appearing to read "James E. Garrett Jr.", written over a light blue grid background.

James E. Garrett Jr.

Chairman

Sincerely,

A handwritten signature in black ink, appearing to read "Teri L. Cardwell", written over a light blue grid background.

Teri Cardwell

Vice Chairman

Senator Jean D. Breaux  
Assistant Minority Leader  
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Health & Provider Services, RMM  
Utilities, RMM  
Environmental Affairs  
Ethics  
Homeland Security, Transportation & Veteran Affairs  
Joint Rules  
Local Government  
Rules & Legislative Procedure

October 15, 2013

Greetings Colleagues,

Before you is a copy of this year's annual report of the Interagency Council on Black and Minority Health.

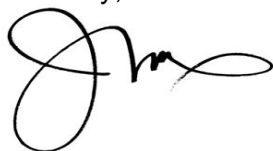
Governed by State Statute, IC 16-46 6, 1-13, the Interagency Council on Black and Minority Health was legislatively introduced by Representative Charlie Brown and enacted into law in 1993. It has been my honor to serve as Chair and member of this council for several years.

Both Representative Brown and I encourage you to take some time to review the attached document. It provides trends on issues affecting minority health conditions across Indiana as well as recommendations members of the council believe to be important in addressing some of the many disparities that continue to plague communities of color throughout Indiana.

Upon review of this document, if you have questions or comments you would like council members to address, please do not hesitate to contact Representative Brown or me. Additionally, as policy makers, if you have ideas you feel may help address concerns statutorily required by the Interagency Council to consider, please forward those as well.

Thank you for your review and consideration of this document and the important information contained therein.

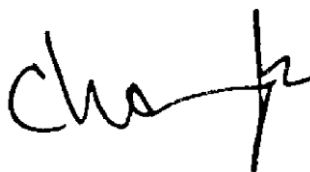
Sincerely,



Jean D. Breaux

Assistant Minority Leader

Indiana Senate District 34



Charlie Brown

State Representative

Indiana House District 3

## **Executive Summary**

### **Health Equity**

When all people have "the opportunity to 'attain their full health potential' and no one is 'disadvantaged from achieving this potential because of their social position or other socially determined circumstance.'" -- PA Braveman (2003)

Health equity is an ideal state where there are no differences in the health outcomes among groups of people based on the social determinants. Conversely, health *inequity* is a difference or disparity in health outcomes that is systematic, avoidable, and unjust. Health inequities are the result of health *disparities* which are a type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. (Healthy People 2020 as cited by the Centers for Disease Control).

### **Looking ahead at 2014**

Health care disparity is a non-partisan issue that should be at the forefront of the Indiana legislative agenda. This year's Interagency Council on Black and Minority Health report clearly demonstrates both progress and challenges in reducing health disparities among Indiana's minority populations. The agencies participating in the Interagency Council proceedings represent a cross-section of providers that serve Indiana's growing minority populations. As these populations continue to grow, it will be imperative to collect, monitor and evaluate data in order to provide accurate information about the health of all Indiana residents. These three include reproductive health, mental health, and infant mortality.

This year we have chosen to update the dashboard that was presented in 2012 and formulate recommendations that will help improve health outcomes for Indiana residents. The purpose of the dashboard is to give a snapshot of the state's progress on the focus areas in the Healthy Indiana – A Minority Health Plan for The State of Indiana – HEAL the Gap, as well as Healthy People 2020 objectives. Evaluating the present data allows public health and those that do programming to develop culturally sensitive and timely interventions to reduce health inequity. Below you will find those diseases most prevalent within racial and ethnic minorities, their current status, and what the council recommends in order to address these growing trends and help in the efforts of eliminating health disparities. These include heart disease, cancer, diabetes, asthma, HIV/AIDS, and infant mortality. For a more detailed account, please refer to the dashboard in its entirety within the annual report.

## **Heart Disease**

Heart disease is the leading cause of death for every race, ethnic group, and gender in the United States. Coronary heart disease death rates among African Americans and Hispanics have decreased. Despite a downward trend in coronary heart disease deaths in African Americans, hypertension (high blood pressure) and high cholesterol levels are rising and this remains a major health concern. Both are risk factors for heart disease and stroke.

### **Current Issues:**

Current death rates among Hispanics (65.5 per age adjusted deaths per 100,000) meets targeted objective that is outlined in the 2001 HEAL The Gap document as well as the Healthy People 2020 objectives (108 deaths per 100,000 population)

In comparison, the coronary heart disease death rate for African Americans (128.7 age adjusted deaths per 100,000 population) exceeds the HEAL the gap and the Healthy People 2020.

### **Recommendations from Council:**

1. The Interagency Council on Black & Minority Health support the creation of enhanced and improved quality of stroke systems of care inclusive of improving community education, prevention, immediate medical care, proper notification of emergency care, treatment and rehabilitation (American Heart Association.)
2. Establish, build and create healthier environments that empowers awareness and education and promote increased physical activity, improve proper nutrition, and generate healthier lifestyles via legislative and grassroots activities that include procurement of healthier foods offered and served to the public, reduction of obesity in adults and children, elimination of food deserts, early detection and screenings, community based education and risk reduction services focusing on hypertension within minority population.
3. Increase opportunities to educate Black or African American adults about the dangers of high blood pressure and its complications (e.g., damage to the heart, blood vessels, brain, kidneys, and eyes), and the behaviors that increase the risk for high blood pressure (e.g., cigarette smoking, obesity, physical inactivity, high dietary fat and sodium, excessive alcohol consumption, etc.).

## **Cancer**

Cancer rates vary among and within different racial and ethnic groups. The highest age adjusted mortality rate occurs in Blacks. The age-adjusted overall cancer death rate among African Americans decreased, but did not meet the target objective outlined in the 2001 HEAL the Gap. Also, the death rate for African Americans does not meet the

Healthy People 2020 objective of 160.6 overall cancer deaths per 100,000 populations. The most common forms of cancer mortality include: lung, breast, colon, and prostate cancers.

### **Current Issues**

Increase the proportion of women aged 40 years and older among Indiana's Black or African American population who have received a mammogram within the preceding 2 years from 85.2% (2001) to 90.0. The state has only reached 68%.

Increase the proportion of women among Indiana's Black or African American population who receive a Pap test from 96.4% (2000) to 100.0%. The state percentage as of date was 76.6%.

Recommendations from Council:

1. Increase opportunities for Black or African American persons to learn more about cancer, its risk factors, and the importance and methods of early detection through culturally appropriate promotional, educational, and community campaigns.
2. Promote among Indiana's health care professionals the use of the U.S. Preventive Services Task Force (USPSTF) guidelines for cancer screenings, diagnosis, and management advanced by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).
3. Conduct an exploratory study on why cancer has become the number one cause of death for African Americans surpassing Heart Disease Indiana.

### **Diabetes**

The age-adjusted diabetes death rates among African Americans (47.7 age-adjusted deaths per 100,000) and Hispanics (19.6 age-adjusted deaths per 100,000) decreased. These rates met and exceeded the 2001 HEAL the Gap target objective and the Healthy People 2020 objective to reduce the overall diabetes death rate to 65.8 deaths per 100,000 population.

### **Current Issues**

Despite the downward trends in deaths due to diabetes, African Americans continue to disproportionately suffer from complications due to diabetes such as kidney disease, neuropathy, and amputations.

Recommendations from Council:

1. Partner with the Indiana University School of Optometry, the Indiana Optometric Association, and Prevent Blindness Indiana to promote annual eye examinations through local churches, community health centers, and minority health coalitions.
2. Support partnerships and coalitions that improve dietary quality, increase physical activity and reduce obesity across multiple settings—such as child care

facilities, workplaces, hospitals and medical care facilities, schools, and communities.

3. Create and maintain a chronic disease registry system that collects chronic disease related data to measure and assess the health status of Indiana's Black or African American, Hispanic or Latino, and other high risk racial and ethnic minority populations.

### **HIV/AIDS**

The prevalence of AIDS among African Americans has decreased to from 346.6 per 100,000 (2003) population to 329.9 cases per 100,000 (2011), but it does not meet the target objective of 232.2 cases per 100,000 outlined in the 2001 HEAL the Gap. This would be a 33% improvement.

### **Current Issues**

The prevalence of HIV/AIDS among African Americans and Hispanics increased to 636.5 and 200.2 cases per 100,000, respectively. The target objectives in HEAL the Gap were 250.0 cases per 100,000 for African Americans and 79.1 cases per 100,000 for Hispanics. The prevalence of AIDS cases among Hispanics has also increased from 104.0 to 118.8 cases of AIDs per 100,000 Hispanic/Latino persons.

Recommendations from Council:

1. Continue to assess the unmet needs of people living with HIV/AIDS.
2. Increase funding to provide services to meet the unmet needs of people living with HIV/AIDS.
3. Expand opportunities and venues to provide African Americans, Hispanics and other high risk racial and ethnic minority communities with education, testing, treatment and prophylaxis consistent with U.S. Preventive Services Task Force recommendations.

### **Asthma**

In 2011, the age-adjusted rate of asthma deaths among African Americans was unstable. The unstable rate could be attributed to a small population and/or a small number of deaths.

### **Current Issues**

There was no data available to assess the effect asthma has on school or work attendance.

Recommendations from Council:

1. Support efforts to standardize collection and reporting of race, ethnicity and language data, as well as provide accurate and quality data on all populations in Indiana.



2. Increase funding for the Behavioral Risk Factor Surveillance System (BRFSS) to oversample racial/ethnic minorities and increase the number of completed informational and data surveys obtained from Black or African American, Hispanic or Latino, and other high risk racial and ethnic minority communities.

### **Infant Mortality**

In 2011, the infant mortality rate among African Americans (12.3 infant deaths per 1,000 live births) was twice that of the target objective (6.7 infant deaths per 1,000 live births) outlined in HEAL the Gap and the HP 2020 target objective to reduce the rate of all infant deaths (within 1 year) to 6.0 infant deaths per 1,000 live births.

### **Current Issues**

While the rate of infant deaths among African Americans has declined, it remains the highest among all Indiana populations. The percent of low birth weight infants among African Americans (13.3% of Live births) was twice that of the target objective outlined in HEAL the Gap and Healthy People 2020 objective of 7.8 percent of live births.

Recommendations from Council:

1. Create effective and coordinated operational linkages between services available to Black or African American females (e.g., Women, Infants, and Children (WIC) programs, community health centers, minority health coalitions, Prenatal Substance Abuse Prevention Programs (PSUPP) (if needed), tobacco cessation programs (if needed), local Medicaid offices, and community nutrition programs.

The data collected for the report indicate there are aspects of minority health that have improved within the past 5-10 years. The indicators of progress are directly related to an emphasis by local minority-serving organizations to engage communities of color. This grassroots engagement increases community ownership of initiatives to improve health outcomes. The areas of improvement are a result of the collaboration of Indiana communities with state and local divisions of government to identify, intercede and support minority communities to have a positive influence to improve health dimensions included in this report.

While there is much to celebrate about improving trends of health status among Indiana's minority populations, as a statutorily sanctioned Council we are also concerned about areas where there is stagnation, or worse, a trend denoting reversal of health. Infant mortality, different types of cancer, sexually transmitted infections, and mental health concerns continue to disproportionately affect minority populations. Closely linked with these disparities are the social determinants of health that greatly impact the ability of minority groups to access health and related services, prenatal care, and disease-specific screening services. Therefore, reducing disparities and

improving trends toward health equity are directly related to improving social and economic conditions for all Indiana residents.

The effectiveness of the Affordable Care Act will not be evident for several years, however the legislation has already had a positive influence on reducing health disparities by making preventive services available to many more Indiana residents. There are many building blocks to the foundational principles of the ACA. Indiana has an unprecedented opportunity to improve the state's status on multiple health indicators by promoting education, prevention, and access in its deliberation of health-related legislation.

## **Overview of the Interagency State Council on Black & Minority Health**

In 1992, legislation was passed to adopt the first five-year Strategic Plan on Minority Health for Indiana, as well as the appropriation of a budget to carry out programming. The Indiana General Assembly also passed legislation creating the Interagency State Council on Black and Minority Health (IAC). *Indiana Code 16-46-6* directed the Indiana State Department of Health (ISDH) to establish the IAC with representation from the Indiana House of Representatives, Indiana Senate, and Governor's Office, as well as various other agencies and organizations (Table 1).

<http://www.ai.org/legislative/ic/code/title16/ar46/ch6.html>.

Table 1. The Interagency State Council on Black and Minority Health Members –2012-2013

<b>Statutory appointees:</b>	
Two (2) members of the House of Representatives from different political parties appointed by the Speaker of the House of Representatives.	Rep. Charlie Brown – D Rep. Bob Morris – R
Two (2) members of the Senate from different political parties appointed by the President pro tempore of the Senate.	Senator Jean Breaux – D Senator Veneta Becker – R
The Governor or the governor's designee.	Jamal Smith
The State Health Commissioner or the commissioner's designee	William C. VanNess II, MD Antoniette Holt (Proxy)
The director of the Division of Family Resources or the director's designee	James Garrett , Jr.
The director of the Division of Mental Health and Addiction or the director's designee	Lynn Smith
The commissioner of the Department of Corrections or the commissioner's designee	Edwin G. Buss Tim J. Brown & Rose Vaisvilas (Proxy)
<b>Governor's appointments:</b>	
One (1) representative of a public health care facility appointed by the governor	Jose M. Pérez

One (1) member appointed by the governor based on the recommendation of the Indiana State Medical Association	Dr. Meredith Cousin
One (1) member appointed by the governor based on the recommendation of the American Medical Association	Lili A. Leavell-Hayes, M.D. (Passed 3-16- 2013)
One (1) member appointed by the governor based on the recommendation of the Indiana Hospital and Health Association	Dr. Edward Williams
One (1) member appointed by the governor based on the recommendation of the American Heart Association	Lynne Griffin
One (1) member appointed by the governor based on the recommendation of the Black Nurses Association	Maple Murrell
One (1) member appointed by the governor based on the recommendation of the Indiana Minority Health Coalition	Teri Cardwell
<b>Invited Advisors:</b>	
Nancy Jewell, Indiana Minority Health Coalition Edwin Marshall, Indiana University	
<b>Staff</b>	
Tony Gillespie, Indiana Minority Health Coalition Calvin Roberson, Indiana Minority Health Coalition Shanta Harris, Indiana Minority Health Coalition JoeAnn Gupton, Office of Minority Health, ISDH Adrienne Durham, Office of Minority Health, ISDH	

## **Emerging Issues**

The Interagency State Council on Black & Minority Health is tasked to give an overview of what is occurring within Indiana among racial and ethnic minorities. The charge given is to examine diseases and issues that are effecting these different and diverse communities and inform Indiana's legislative body of current problems. This year we will highlight four health issues:

- Social determinants of health;
- Mental health;
- Reproductive health; and,
- Infant mortality

## **Social Determinants of Health: Indiana Profile**

The following information provides a snapshot of Indiana demographics and change over a period of time, as well as socioeconomic details, insurance coverage and health providers based on the most recent data available. Any values equal to or greater than 1 percent greater difference were listed as having a lower or higher difference. The main source of this information is the U.S. Census Bureau, with other details available from the Health Resources and Services Administration.

### ***Population Characteristics:***

- According to the U.S. Census Bureau, the population in Indiana has grown in size from 1990 to 2010 with an overall increase of 16.9 percent.
- During this time, population for Indiana has become more diverse with an increase in the portion of Asian, Black/African American and Hispanic/Latino populations and a decrease in the portion of Whites.

#### **Indiana Population by Race/Ethnicity for Selected Years**

	1990	2000	2010	2012
<b>Total Population (number)</b>	5,544,156	6,080,486	6,483,802	6,537,334
<b>Race (percentage)</b>				
American Indian/Alaska Native	0.2%	0.3%	0.3%	0.4%
Asian	0.7%	1.0%	1.6%	1.8%
Black/African American	7.8%	8.4%	9.1%	9.4%
Native Hawaiian/Pacific Islander	N/A	0.0%	0.0%	0.1%
White	90.6%	87.5%	84.3%	86.6%

**Ethnicity (percentage)**

Hispanic/Latino ‡	1.8%	3.5%	6.0%	6.3%
Non-Hispanic/Latino	98.2%	96.5%	94.0%	93.7%

Notes: N/A = not available as Native Hawaiian/Pacific Islander was combined with Asian. ‡ Hispanic/Latino populations may be of any race.

Sources: U.S. Census Bureau, 1990 Census, 2000 Census and 2010 Census, Retrieved from [www.factfinder2.census.gov](http://www.factfinder2.census.gov)

Population Estimates, 2012, retrieved from [www.stats.indiana.edu](http://www.stats.indiana.edu)

- From 1990 to 2010, the distribution of the population by age group in Indiana is similar for most groups with the exception of a decrease in the portion of the population in the 25 to 44 age group.
- In 2012, it was estimated that forty percent (40.1%) of the Indiana population is 45 years or older. Adults 45 to 64 years of age comprise 26.5% of the population and 13.6% of adults are 65 years and older.

**Indiana Population by Age Group for Selected Years**

	1990	2000	2010	2012
<b>Age Group (percentage)</b>				
0 to 4 years	7.3%	7.0%	6.7%	6.5%
5 to 17 years	19.0%	18.9%	18.1%	17.8%
18 to 24 years	10.9%	10.2%	10.0%	10.1%
25 to 44 years	31.2%	29.4%	25.6%	25.4%
45 to 64 years	18.9%	22.3%	26.5%	26.5%
65 years and older	12.5%	12.4%	13.0%	13.6%

Sources: U.S. Census Bureau, 1990 Census, 2000 Census and 2010 Census retrieved from [www.factfinder2.census.gov](http://www.factfinder2.census.gov)

Population Estimates, 2012, retrieved from [www.stats.indiana.edu](http://www.stats.indiana.edu)

## Indiana Estimated Percent Living Below the Poverty Level by Age Groups 2007-2011

### Below Poverty

#### Age Group

Under 18 years	19.9%
18 to 64	13.1%
65 years and older	7.6%

Source: U.S. Census Bureau, 2007-2011 American Community Survey, Retrieved from [www.factfinder2.census.gov](http://www.factfinder2.census.gov)

According to the most recent estimates, the minority population in Indiana experiences disparities in educational attainment, income, poverty, employment and health insurance. The source for the following information is the 2007-2011, American Community Survey (ACS) [www.factfinder2.census.gov](http://www.factfinder2.census.gov) with the exception of uninsured which was retrieved from the 2009-2011 ACS.

- Educational attainment of a high school diploma or higher among adults 25 and older was lower for Hispanic/Latinos (61.2%), American Indian/Alaska Natives (81.3%), Black/African Americans (83.5%), and Asians (87.0%) compared to Whites (88.0%).
- Median household income was lower for Black/African Americans (\$30,898), Native Hawaiian/Pacific Islander (\$31,705), American Indian/Alaska Natives (\$37,517), and Hispanic/Latinos (\$37,148), compared to Whites (\$50,839).
- Per capita income was lower for Hispanic/Latinos (\$13,522) Black/African Americans (\$16,843), Native Hawaiian/Pacific Islander (\$17,608), and American Indian/Alaska Natives (\$19,099) compared to Whites (\$25,908).
- The portion of individuals living below the poverty level is higher among Black/African Americans (29.4%), Hispanic/Latinos (27.4%), Native Hawaiian/Pacific Islander (25.0%), Asians (19.2%), and American Indian/Alaska Natives (17.8%) compared to Whites (11.8%).
- The unemployment rate is higher among Black/African Americans (17.1%), American Indian/Alaska Native (15.3%), Native Hawaiian/Pacific Islander (14.2%), and Hispanic/Latinos (12.2%) compared to Whites (8.1%).
- The portion of uninsured is higher among Hispanic/Latinos (30.1%), Native Hawaiian/Pacific Islander (25.2%), American Indian/Alaska Native (22.8%), Black/African Americans (19.2%), and Asians (16.2%) compared to Whites (13.4%).

### **Health Resources:**

According to the 2012 America's Health Rankings published by the United Health Foundation, the overall ranking of Indiana is 41 out of 50 states. More specifically, Indiana ranked 44<sup>th</sup> in smoking, 43<sup>rd</sup> in all determinants (behaviors, community & environment, public and health policies, and clinical care), 42<sup>nd</sup> in obesity, 41<sup>st</sup> in cancer deaths, 38<sup>th</sup> in cardiovascular deaths, and 33<sup>rd</sup> in diabetes prevalence [AHR]. A portion of Indiana has been designated as medically underserved, and there is a lack of primary medical, dental and mental health professionals.

There are 53.6 primary care physicians per 100,000 population and 58.3 dentists per 100,000 population [HWS].

**Sources:**

2012 America's Health Rankings [AHR]; <http://www.americashealthrankings.org/>

Health Workforce Studies [HWS]; <http://ahec.iupui.edu/indiana-center-for-health-workforce-studies-reports/>

Stats Indiana 2012 Population Estimates, 2012, retrieved from [www.statsindiana.edu](http://www.statsindiana.edu)

US Census Bureau [USCB] 1990 Census, 2000 Census and 2010 Census, 2007-2011 American Community Survey 5-Year Estimates and 2009-2011 American Community Survey 3-year Estimates, [www.factfinder2.gov](http://www.factfinder2.gov)

## **Mental Health**

### **DIVISION OF MENTAL HEALTH AND ADDICTION SUICIDE PREVENTION**

In 2009, the Division of Mental Health and Addiction (DMHA) targeted their interest on building an integrated and collaborative network of community organizations and state agencies to focus on suicide prevention and awareness. DMHA, in conjunction with the Indiana State Department of Health (ISDH) gathered information about suicide prevention and awareness efforts in the state, as well as identify any gaps in services.

In early 2010, DMHA conducted a "State of Suicide" survey. The goal of the survey was to create a snapshot of current suicide prevention and intervention services in the state. Upon completion of the survey, DMHA and ISDH identified key stakeholders to convene a Suicide Prevention Summit to review and clarify the survey results, discuss the gaps in services and future needs for suicide prevention activities.

From this summit, key stakeholders were identified for the Indiana Suicide Prevention Advisory Committee. The committee reviewed and analyzed several state suicide prevention plans as well as national strategies to discuss and select features that could be utilized in Indiana's suicide prevention plan. This information, along with the findings of the survey and summit, were the framework for Indiana's plan. The Indiana suicide prevention plan was completed and printed along with a brochure in SFY 2013. A website was also created at [www.in.gov/issp/files/plan.pdf](http://www.in.gov/issp/files/plan.pdf), where an electronic copy of the Indiana State Suicide Prevention Plan and other resources are available.



## **Reproductive Health**

Healthy People 2020 (n.d.) includes sexual health as one of the twenty leading health indicators (LHI), including women who sought preventive services such as mammograms and pap smears and persons living with HIV who know their serostatus. While this report addresses the needs of various racial and ethnic communities, little data is collected by Indiana for races other than African American and White.

In preparation for the 2013 report, various sources were reviewed for the most recent data available on indicators of sexual health, including those listed above. Data from the Indiana State Department of Health Division of HIV and STDs, Kaiser Family Foundation, Healthy People 2020, American Cancer Society, National Cancer Institute, and the Centers for Disease Control provide the foundation for information in this report. Although a few areas show improvement, minorities, particularly African Americans, have disproportionately high rates of sexually transmitted and reproductive associated diseases.

Overall, among males, incidence and death rates are higher for African Americans than Whites for all cancers combined and for the most common cancers including prostate cancer. In contrast, African American women have a lower risk of cancer overall than white women, largely due to lower incidence rates for the two most common cancers, breast and lung. Although the incidence rates are lower, African American women have higher mortality rates overall.

## **Men's Prostate Health**

The American Cancer Society estimates approximately 35,430 new cases of prostate cancer will occur among African American men in 2013, representing 1 in 5 men. The death rate among African American men in Indiana from prostate cancer is 45.3 per 100,000 population; this is slightly lower than the US prostate cancer death rate for African American males of 50.9 per 100,000 population. The charts below show the complete prevalence (Table 1) and death rate (Table 2) comparisons between African American and white men for prostate cancer. Data is available only for African American and White races.

<b>Complete Prevalence By Race</b> <b>Prostate, All Ages, By Years Since Diagnosis</b> <b>Table 1</b>			
	<b>complete</b>	<b>0 to &lt;35 yrs</b>	<b>35+ yrs</b>
<b>White Male</b>	2,184,988	2,183,280	1,708
<b>Black Male</b>	332,415	332,272	143

Cancer sites include invasive cases only unless otherwise noted.  
 Prevalence Source: SEER November 2012 submission.  
 US Estimated Prevalence counts were estimated by applying US populations to [SEER](#)  
[9](#) Limited Duration Prevalence proportions.  
 Source: <http://seer.cancer.gov/faststats/selections.php?#Output>

<b>Prostate Cancer Death Rates by Race</b> <b>Total US Male Population</b> <b>Table 2</b>	
<b>Race/Ethnicity</b>	<b>Male</b>
All Races	23.0 per 100,000 men
White	21.2 per 100,000 men
Black	50.9 per 100,000 men
Asian/Pacific Islander	10.1 per 100,000 men
American Indian/Alaska Native <sup>a</sup>	20.7 per 100,000 men
Hispanic <sup>b</sup>	19.2 per 100,000 men

Source: National Cancer Institute. <http://seer.cancer.gov/statfacts/html/prost.html>

### **Women's Reproductive Health**

Kaiser Family Foundation data (2010) indicates that rates of women age 15-44 years who received a pap smear in the last 3 years were similar among white and Black populations. The rate in the United States for white women was 82.5% and 85.4% for African American women. Indiana women, however, seek this preventive service at a lower rate than the national average for white women (79.5%), and at a slightly higher rate for African American women (86.6%). This would imply that there is greater health equity among African American women for this indicator.

Conversely, mammogram services are significantly lower for both African American and White Indiana women than the total US female population. The US total population of females over the age of 50 has a rate of 78.1% for white women, and 82.1% for African American women. In Indiana, African American women are at a rate of 77.8% as compared to 74.7% among white women in the state. (ACS; retrieved 9/23/13).

Ovarian cancer is the 10<sup>th</sup> most common cancer diagnosis among African American women, and 5<sup>th</sup> in overall cancer mortality.

### **HIV/AIDS**

Incidence rates for Kaposi sarcoma (KS) is more than twice as high in African Americans as compared to Whites. Although KS is now a relatively rare cancer, incidence rates are 2.7 times higher in African American men compared to white men and 3.6 times higher in African American women compared to white women. In the US, KS primarily occurs among people infected with human immunodeficiency virus (HIV). (ACS; retrieved 9/23/13).

Kaiser Family Foundation estimates a total of 230,421 HIV diagnoses among African Americans in the United States. This equates to a rate per 100,000 in Indiana of 226 among African Americans compared to 229 among Whites. HIV/AIDS epidemiology data reported by the Indiana State Department of Health for 2011 indicate that 44.6% of all new diagnoses are among African Americans representing a rate nearly three times higher than Hispanics and eight times higher than Whites. African American males have the highest rate (63.5) of new diagnoses. More than half of all children born with HIV are African American, (50.3%) as compared to 31.2% White, and 9.3% Hispanic.

### **Sexually Transmitted Diseases**

Chlamydia often has no symptoms and goes without diagnosis. The CDC surveillance statistics for STDs ranks Indiana 25<sup>th</sup> among all states with more than 27,000 cases of chlamydia in 2011, representing a case rate of 428.6 per 100,000 population.

Syphilis cases reported by the CDC for 2011 placed Indiana at 26<sup>th</sup> among all states with 173 cases of primary and secondary syphilis, or a 2.7 case rate per 100,000 population. During 2010–2011, the nationwide rate of primary and secondary syphilis increased 4.5% among Hispanics (from 4.4 to 4.6 cases per 100,000 population), 8.0% among American Indians/Alaska Natives (from 2.5 to 2.7 cases per 100,000 population), 9.5% among non-Hispanic whites (from 2.1 to 2.3 cases per 100,000 population), and 33.3% among Asian/Pacific Islanders (from 1.2 to 1.6 cases per 100,000 population). The rate decreased 6.6% among non-Hispanic blacks (from 16.6 to 15.5 cases per 100,000 population).

In 2011, Indiana reported 6,569 cases of gonorrhea to CDC surveillance, ranking the state 21<sup>st</sup> with a case rate of 101.3 per 100,000 population. In 2011, gonorrhea rates remained highest among Blacks (427.3 cases per 100,000 population) and was 17.0 times the rate among whites (25.2 per 100,000 population). The gonorrhea rate among American Indians/Alaska Natives (115.7) was 4.6 times that of whites, and the rate among Hispanics (53.8) was 2.1 times that of whites.

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## **Infant Mortality**

The Affordable Care Act (ACA) is a sweeping landmark legislation in United States public health policy. The ACA attempts to provide near-universal guarantee of access to affordable health insurance coverage for millions of currently uninsured or underinsured Americans'. The implementation of this law is very timely for Hoosiers across Indiana, especially for Hoosiers of color, as Indiana continues to grapple with one of the highest infant mortality rates in the nation.

The mortality rate for infants is determined by the number of children per every 1,000 live births who die before 12 months of age or their first birthday. Indiana's infant mortality rate ranks among the highest in the nation. In 2010, Indiana was among thirteen states with infant mortality rates ranging from 7.00 to 7.99 infant deaths per every 1,000 live births. Two states had infant mortality rates of 8.0 or higher. According to a National Center for Health Statistics preliminary 2011 data report, the overall infant mortality in the United States is 6.05 infant deaths per every 1,000 live births. The overall infant mortality rate in Indiana is 7.7 infant deaths per every 1,000 live births. Table 1 shows the most current infant mortality rates in Indiana by race and ethnicity. The infant mortality rate among black and other races is an astounding and disturbing 12.3 and 9.3 infant deaths per 1,000 live births, respectively. Black infants are nearly two times more likely to die before they reach age one than white infants in Indiana.

**Table 1.**  
**Infant Mortality Rate by Race and Ethnicity – Indiana, 2011**

	Live Births	Infant Deaths	Infant Death Rates
All Races	83,750	643	7.7
White	69,349	479	6.9
Black	9,908	122	12.3
Other	4,493	42	9.3
Hispanic*	8,105	53	6.5

\*Hispanic can be of any race.

Rate per 1,000 live births.

Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

According to the Indiana State Department of Health, infant mortality “reflects the overall state of maternal health.” Lack of resources, policies, and access to quality healthcare all compromise the safety and survival of Indiana's most vulnerable women and children.

As policy makers we should be gravely concerned about Indiana's infant mortality ranking and the health of our state's children. If infant mortality is the indicator used to determine the health and viability of a population, then Indiana has considerable work to do to ensure its most vulnerable are healthy with every opportunity to thrive.

As we continue to debate the merits of the Affordable Care Act and its implementation in Indiana, may we not lose sight of the impact access to affordable and comprehensive health care has on a society and on that society's ability to promote health and well-being to its citizens.

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### **Dashboard: Indiana's Progress in Health**




The Indiana State Department of Health (ISDH) established the Indiana Minority Health Advisory Committee (InMHAC) in 2000 under the Indiana Minority Health Initiative. The purpose of the InMHAC was to provide advice and guidance to the ISDH in addressing racial and ethnic minority health disparities. In 2001, the InMHAC was charged with developing a plan for eliminating health disparities in Indiana. As a result, the Healthy Indiana – A Minority Health Plan for The State of Indiana – **H**Health **E**quality **A**ccess **L**eadership (HEAL) the Gap was created with heart disease, cancer, stroke, asthma, diabetes, HIV/AIDS, and infant mortality as its focus areas. The Minority Health Plan objectives were based on the Healthy People 2010 objectives and they serve as the framework of the plan [Indiana State Department of Health, Minority Health Advisory Committee, Healthy Indiana - A Minority Health Plan for the State of Indiana **H**Health **E**quality **A**ccess **L**eadership (HEAL) the Gap].

*Healthy People 2020* is a comprehensive health promotion and disease prevention agenda established by the U.S. Department of Health and Human Services. It is built on the 1979 Surgeon General's Report, *Healthy People 2010*, and *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. These objectives are the result of a collaborative effort among the U.S. Department of Health and Human Services, federal agencies, and other experts. For more than 20 years, these objectives have served as the basis for State and local plans to improve health. The four overarching goals of Healthy People 2020 are as follows:

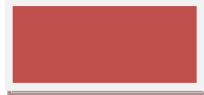

1. Attain higher quality, longer lives free of preventable disease, disability, injury, and premature death
2. Achieve health equity, eliminate disparities, and improve the health of all groups
3. Create social and physical environments that promote good health for all
4. Promote quality of life, healthy development, and healthy behaviors across all life stages.

## **2013 Dashboard**

The Interagency State Council on Black and Minority Health 2013 annual report examines the state's progress on the focus areas of the Healthy Indiana – A Minority Health Plan for The State of Indiana – HEAL the Gap, as well as Healthy People 2020 objectives. The 2013 dashboard reviews specific indicators that include the following objectives: heart disease; stroke; cancer; diabetes; HIV/AIDS; asthma; and infant mortality.

<b>Heart Disease Objectives</b>	<b>Current Value</b>	<b>Trend</b>	<b>Current Data Source</b>
1. Reduce coronary heart disease deaths among Indiana's black or African American population from 224.2 coronary heart disease deaths per 100,000 (2000) to 170.5 deaths per 100,000 (reduce to InMHAC target of 30% improvement).	128.7 age-adjusted deaths per 100,000		Indiana Mortality Report - 2011
2. Reduce coronary heart disease deaths among Indiana's Hispanic Latino population from 159.5 coronary heart disease deaths per 100,000 Hispanic/Latino persons (2000) to 161.1 deaths per 100,000 Hispanic or Latino persons (reduce to InMHAC target of 7% improvement)	65.5 age-adjusted deaths per 100,000		Indiana Mortality Report - 2011
3. Reduce the proportion of adults among Indiana's black or African American adult population aged 20 years and older (2001) with high blood pressure from 35.6% to 16.0% (reduce to HP2010 target).	36.6% of black adults, 18 years and older		2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)
4. Reduce the proportion of adults among Indiana's black or African American population with high total	<b>**</b> 31.6% of black adults, 18 years	Data cannot be compared	2011 Indiana Behavioral Risk



blood cholesterol levels from 20.5 % (2001) to 17.0 % (reduce to HP2010 target).	and older	with previous years	Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)
5. Reduce the proportion of adults among Indiana's Hispanic/Latino population with high total blood cholesterol levels from 28.4 % (2001) to 17.0 percent (reduce to HP2010 target).	<b>**</b> 29.8% of Hispanic or Latino adults , 18 years and older	Data cannot be compared with previous years	2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)
6. Increase the proportion of adults among Indiana's black or African American adult population, 18 years and older, who have had their blood cholesterol checked within the preceding 5 years from 68.5% (2003) to 85% (increase to InMHAC target)	68.0% of black or African American adult population, 18 years and older		2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)
7. Increase the proportion of adults among Indiana's Hispanic/Latino adult population, 18 years and older, who have had their blood cholesterol checked within the preceding 5 years from 47.4% (2003) to 85% (increase to InMHAC target).	51.7% of Hispanic or Latino adults, 18 years and older		2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)

\*Hispanic can be of any race.

**\*\*Beginning in 2011, surveys were conducted via landline and cell phone and the BRFSS began using raking weighting, which is an enhancement over previous post-stratification weighting procedures. Therefore, 2011 data cannot be compared with data from previous years.**

**Source: Indiana State Department of Health, Office of Minority Health, September 2013. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.**




## Heart Disease

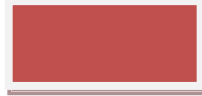

Coronary heart disease death rates among African Americans and Hispanics have decreased. The death rates among both groups exceeded the target objective outlined in the 2001 **HEAL** the Gap document. However, the coronary heart disease death rate for African Americans exceeds the Healthy People 2020 objective of 100.8 deaths per 100,000 population.

Despite a downward trend in coronary heart disease deaths in African Americans, high blood pressure continues to be a major health concern. The proportion of African Americans with high blood pressure increased slightly from 2001 the target objective outlined in the 2001 **HEAL** the Gap document. The percent of African Americans with high blood pressure exceeds the current HP 2020 objective to reduce percent of adults age 18 years and older with high blood pressure/hypertension to 26.9 percent.

High blood pressure and high blood cholesterol levels are risk factors for heart disease and stroke. Since the 2001 **HEAL** the Gap document, there has been little increase in the proportion of African American adults who have had their blood cholesterol checked within the preceding 5 years. In addition, the proportion of African American and Hispanic adults who had their blood cholesterol checked within the preceding 5 years does not meet the Healthy People 2020 objective of 82.1 percent. Due to changes in data collection methods, the 2011 BRFSS data related to the prevalence of high cholesterol cannot be compared with previous years. Therefore, the proportions of African Americans and Hispanics adults who reported having had high cholesterol is not documented.

Data source: National Health and Nutrition Examination Survey (NHANES), CDC/NCHS).

Stroke Disease Objectives	Current Value	Trend	Current Data Source
1. Reduce stroke deaths among Indiana's black or African American population from 92.3 to 55.4 deaths per 100,000 (reduce to InMHAC target of 40% improvements).	57.4 age-adjusted deaths per 100,000		Indiana Mortality Report - 2011
2. Reduce stroke deaths among Indiana's Hispanic/Latino population from 62.5 to 53.1 deaths per 100,000 (reduce to InMHAC target of 15% improvement).	30.5 age-adjusted deaths per 100,000		Indiana Mortality Report - 2011
3. Reduce the proportion of adults among Indiana's black or African American adult population aged 20 years and older (2001) with high blood pressure from 35.6% to 16.0% (reduce to HP2010 target).	36.6% of black adults, 18 years and older		2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)
4. Reduce the proportion of adults among Indiana's black or African American population with high total blood cholesterol levels from 20.5 % (2001) to 17.0 % (reduce to HP2010 target).	**31.6% of black adults ,18 years and older	Data cannot be compared with previous years	2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked

			odd-numbered years only)
5. Reduce the proportion of adults among Indiana's Hispanic/Latino population with high total blood cholesterol levels from 28.4 % (2001) to 17.0 percent (reduce to HP2010 target).	<b>**</b> 29.8% of Hispanic or Latino adults , 18 years and older	Data cannot be compared with previous years	2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked odd-numbered years only)
6. Increase the proportion of adults among Indiana's black or African American adult population, 18 years and older, who have had their blood cholesterol checked within the preceding 5 years from 68.5% (2003) to 85% (increase to InMHAC target)	68.0% of black or African American adult population, 18 years and older		2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS)
7. Increase the proportion of adults among Indiana's Hispanic/Latino adult population, 18 years and older, who have had their blood cholesterol checked within the preceding 5 years from 47.4% (2003) to 85% (increase to InMHAC target).	51.7% of Hispanic or Latino adults, 18 years and older		2011 Indiana Behavioral Risk Factor Surveillance System (BRFSS)





\*Hispanic can be of any race.





Source: Indiana State Department of Health, Office of Minority Health, September 2013. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.



### Stroke Disparities

The age-adjusted stroke death rates among African Americans and Hispanics decreased. Despite the decrease in death rates, the age-adjusted stroke death rate among African Americans does meet the Healthy People 2020 objective of 33.8 deaths per 100,000 population.

Data Source: National Vital Statistics System-Mortality (NVSS-M), CDC/NCHS

Cancer Objectives	Current Value	Trend	Current Data Source
1. Reduce the overall cancer death rate among Indiana's black or African American population from 274.9 cancer deaths per 100,000 to 192.4 deaths per 100,000 (reduce to InMHAC target of 30% improvement).	225.8 age-adjusted deaths per 100,000		Indiana Mortality Report - 2011
2. Reduce the trachea, lung and bronchus cancer death rate for Indiana's black or African American male population (2000) from 110.7 deaths per 100,000 to 86.3 deaths (reduce to HP2010 target of 22% improvement).	89.6 age-adjusted deaths per 100,000		Indiana Mortality Report – 2011 Data compiled by the Indiana State Cancer Registry 11 September 2011.
3. Reduce the trachea, lung and bronchus cancer death rate for Indiana's black or African American female population (2000) from 53.7 deaths to 41.9 deaths per 100,000 (reduce to HP2010 target of 22% improvement).	45.8 age-adjusted deaths per 100,000		Indiana Mortality Report – 20011 Data compiled by the Indiana State Cancer Registry 11 September 2011.
4. Reduce the breast cancer death rate for Indiana's Black or African American female population from 34.7 deaths per 100,000 (2000) to 31.9 deaths per 100,000 (reduce to HP2010 target of 20% improvement).	34.1 age-adjusted deaths per 100,000		Indiana Mortality Report – 2011 Data compiled by the Indiana State Cancer Registry 11 September 2011.
5. Increase the proportion of women aged 40 years and older among Indiana's Black or African	68.0%		2012 Indiana Behavioral Risk

American population who have received a mammogram within the preceding 2 years from 85.2% (2001) to 90.0% of Black or African American women aged 40 years and Older (increased to InMHAC target)			Factor Surveillance System (BRFSS)
6. Reduce the death rate from cancer of the uterine cervix among Indiana's Black or African American population from 4.9 cervical cancer deaths per 100,000 Black African American females (reduce to HP2010 target of 33% improvement)	* Rates based on fewer than 20 cases are unstable.		Indiana Mortality Report – 2011 Data compiled by the Indiana State Cancer Registry 11 September 2011.
7. Increase the proportion of women among Indiana's Black or African American population who receive a Pap test from 96.4% (2000) to 100.0% of Black or African American women aged 18 and older who received a Pap test within the preceding 3 years (increase to InMHAC target)	76.6%		2012 Indiana Behavioral Risk Factor Surveillance System (BRFSS)
8. Reduce the colorectal cancer death rate for Indiana's Black or African American male population from 43.6 colorectal cancer deaths per 100,000 (2000) to 28.3 deaths per 100,000.	23.4 age-adjusted deaths per 100,000		Indiana Mortality Report – 2011 Data compiled by the Indiana State Cancer Registry 11 September 2011.
9. Reduce the colorectal cancer death rate for Indiana's Black or African American female population from 21.4 colorectal cancer deaths per 100,000 (2000) to 14.1 deaths per 100,000 (reduce to HP2010 target of 34% improvement).	16.9 age-adjusted deaths rate per 100,000		Indiana Mortality Report – 2011 Data compiled by the Indiana State Cancer Registry 11 September 2011.

10. Increase the proportion of adults among Indiana's Black or African American population who receive a colorectal screening examination from 38.7% (2001) to 50.0% of Black or African American adults aged 50 and older who received sigmoidoscopy (increase to HP2010 target)	62.1%		2010 Indiana Behavioral Risk Factor Surveillance System (BRFSS) (This question is asked even-numbered years only)
11. Reduce the prostate cancer death rate among Indiana's Black or African American male population from 70.8 deaths per 100,000 (2000) to 44.3 deaths per 100,000 (reduce to InMHAC target of 40% improvement).	45.5 age-adjusted deaths per 100,000		Indiana Mortality Report – 2011 Data compiled by the Indiana State Cancer Registry 11 September 2011.
12. Reduce the oropharyngeal cancer death rate among Indiana's Black or African American population from 5.1 oropharyngeal cancer deaths per 100,000 Black or African American persons (2000) to 3.1 deaths per 100,000 Black or African American Persons (reduce to InMHAC target of 40% improvement).	* Rates based on fewer than 20 cases are unstable.		Indiana Mortality Report – 2011

\*Rates based on fewer than 20 cases are unstable.



Source: Indiana State Department of Health, Office of Minority Health, September 2013. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.



## Cancer Disparities

Similar to national trends, overall cancer deaths have declined in the overall Indiana population. Despite these rate decreases, blacks continue to have the highest overall cancer death rates. The age-adjusted overall cancer death rate among African Americans decreased, but did not meet the target objective outlined in the 2001 **HEAL** the Gap. Also, the death rate for African Americans exceeds the Healthy People 2020 objective of 160.6 overall cancer deaths per 100,000 population. The death rates due to the most common forms of cancer, lung, breast, and prostate among African Americans do not meet the related Healthy People 2020 objectives. Early detection and treatment influence cancer survival. The proportion of African American women aged 40 years and older who received a mammogram in the preceding 2 years has decreased, as well as the proportion of African American women who received a Pap test within the preceding 3 years

Data Source: National Health Interview Survey (NHIS), CDC/NCHS).

Diabetes Objectives	Current Value	Trend	Current Data Source
1. Reduce the diabetes death rate among Indiana's black or African American population from 58.7 deaths per 100,000 (2000) to 29.3 deaths per 100,000 (reduce to InMHAC target of 50% improvement).	47.7 age-adjusted deaths per 100,000		Indiana Mortality Report - 2011
2. Reduce the diabetes death rate among Indiana's Hispanic population from 51.7 deaths per 100,000 to 25.9 deaths per 100,000 (reduce to InMHAC target of 50% improvement).	19.6 age-adjusted deaths per 100,000		Indiana Mortality Report - 2011
3. Reduce the prevalence of diabetes among Indiana's Black or African American population from 53.0 cases to <b>**</b> 26.5 cases per 1,000 (reduce to InMHAC target of 50% improvement). Change to prevalence % instead of cases per 1000?	13.5%	The data source used for the original targeted objective is not known. It does not appear to be the same data source. Therefore, the two measures cannot be compared to each other.	2012 Indiana Behavioral Risk Factor Surveillance System (BRFSS)




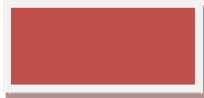
\*Hispanic can be of any race.

\*\*cases per 1,000 **cannot** be compared to percent of adults 18 years and older

Source: Indiana State Department of Health, Office of Minority Health, September 2013. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

## Diabetes

The age-adjusted diabetes death rates among African Americans and Hispanics decreased. These rates met and exceeded the HP 2020 objective to reduce the overall diabetes death rate to 65.8 deaths per 100,000 population. Despite the downward trends in deaths due to diabetes, African Americans continue to disproportionately suffer from complications due to diabetes, such as kidney disease, neuropathy, and amputations.

HIV/AIDS Objectives	Current Value	Trend	Current Data Source
1. Reduce the prevalence of HIV/AIDS among Indiana's black or African American population from 416.6 cases of HIV/AIDS per 100,000 (2000) to 250.0 cases per 100,000 (reduce to InMHAC target of 40% improvement).	636.5 cases per 100,000		June 30, 2012 ISDH HIV Surveillance, eHARS
2. Reduce the prevalence of HIV/AIDS among Indiana's Hispanic/Latino population from 131.9 cases per 100,000 (2002) to 79.1 cases per 100,000 (reduce to InMHAC target of 40% improvement).	200.2 cases per 100,000		June 30, 2012 ISDH HIV Surveillance, eHARS
3. Reduce the prevalence of AIDS among Indiana's black or African American population from 346.6 cases of AIDS per 100,000 (2002) to 232.2 cases per 100,000 black or African American persons (reduce to InMHAC target of 33% improvement).	329.9 cases per 100,000		June 30, 2012 ISDH HIV Surveillance, eHARS
4. Reduce the prevalence of AIDS among Indiana's Hispanic/Latino population from 104.0 cases of AIDs per 100,000 Hispanic/Latino persons (2002) to 69.7 cases of AIDS per 100,000 Hispanic/Latino persons (reduce to InMHAC target of 33% improvement).	118.8 cases per 100,000		June 30, 2012 ISDH HIV Surveillance, eHARS

Hispanic can be of any race.

Indiana State Department of Health, Office of Minority Health, September 2012. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission. Division of HIV/STD.

#### HIV/AIDS Disparities

The prevalence of HIV and AIDS among African Americans and Hispanics increased from the baseline rates outlined in **HEAL** the Gap.


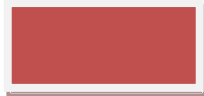


<b>Asthma</b>	<b>Current Value</b>	<b>Trend</b>	<b>Current Data Source</b>
1. Reduce asthma deaths among Indiana's black or African American population from 6.3 to 3.8 deaths per 100,000 (reduce to InMHAC target of 40% improvement)	* Rates based on fewer than 20 cases are unstable.		Indiana Mortality Report - 2011
2. Reduce the number of school or work days missed among Indiana's racial and ethnic populations by persons with asthma due to asthma.	Data not available		None

\*Rates based on fewer than 20 cases are unstable.

Source: Indiana State Department of Health, Office of Minority Health, September 2013. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

### Asthma

In 2011, the age-adjusted rate of asthma deaths among African Americans was unstable. The unstable rate could be attributed to a small populations and/or a small number of deaths. There was no data available to assess the effect asthma has on school or work attendance.

Infant Mortality Objectives	Current Value	Trend	Current Data Source
1. Reduce infant deaths (within 1 year of birth) among Indiana's black or African American population from 15.9 per 1,000 live births (2000) to 6.7 per 1,000 live births (reduce to rate for Indiana White population).	12.3 infant deaths per 1,000 live births		Indiana Mortality Report - 2011
2. Reduce low birth rate (LBW) among Indiana's black or African American population from 12.7% of live births (2000) to 6.7% of live births (reduce to rate for Indiana White population).	13.3% of live births		Indiana Natality Report - 2011
3. Reduce low birth rate (LBW) among Indiana's Asian/Pacific Islander population from 7.3% of live births (2000) to 6.7% of live births (reduce to rate for Indiana White population).	8.1 % of live births		Indiana Natality Report - 2010
4. Reduce very low birth rate (VLBW) among Indiana's black or African American population from 2.9% of live births (2000) to 1.2% of live births (reduce to rate for Indiana White population).	3.0% of live births		Indiana Natality Report - 2011

Source: Indiana State Department of Health, Office of Minority Health, September 2013. Original data obtained from Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team.

### Infant Mortality Disparities

While the rate of infant deaths among African Americans has declined, it remains the highest among all Indiana populations. In 2011, the infant mortality rate among African Americans was twice that of the target objective outlined in HEAL the Gap and the HP 2020 target object to reduce the rate of all infant deaths (within 1 year) to 6.0 infant deaths per 1,000 live births. In addition, the percent of low birth weight infants among African Americans was twice that of the target objective outlined in HEAL the Gap and HP 2020.



### Data Limitations

Indiana State Department of Health, Public Health and Preparedness Commission, Epidemiology Resource Center, Data Analysis Team follows the "Rule of Twenty" when examining rates. There should be at least twenty events in the numerator in order to produce a stable rate. When the numerator is less than 20, the rate is unstable, meaning that a small change in the numerator can lead to a large change in the rate from one year to the next. Unstable rates are not useful when making decisions and how data are interpreted is very important to the decision-making process. Misinterpretation of the data can lead to incorrect assumptions about health status.

Blacks or African-Americans are the largest minority group in Indiana. There is limited published data on American Indians, Asians, and Hispanics, due to their smaller numbers. Data on these minority groups are often suppressed and referred to as "statistically insignificant", because the rates are so low. Therefore, much of the data in this report focuses on the disparities between whites and blacks or African-Americans.

Accurate and quality data are needed to detect and eliminate health disparities. Therefore, health disparities data is impacted by the lack of standardized collection and reporting of race, ethnicity, and language.

### **End Notes**

**Age-Adjusted Rate** – When comparing rates over time or across different populations, crude rates (the number of deaths per 100,000 persons) can be misleading, because differences in the age distribution of the various populations are not considered. Since death is age-dependent, the comparison of crude rates of death can be especially deceptive. Age adjustment, using the direct method, is the application of age-specific rates in a population of interest to a standardized age distribution in order to eliminate differences in observed rates that result from age differences in population composition. According to the National Center for Health Statistics (NCHS), age adjustment is usually done when comparing two or more populations at one point in time or one population at two or more points in time.

**The Behavioral Risk Factor Surveillance System (BRFSS)** is a state-based system of health surveys created by the Centers for Disease Control and Prevention (CDC) in 1984 to gather information on the health of adults ages 18 years and older. State health departments conduct the BRFSS surveys continuously through the year using a standardized core questionnaire and optional modules, plus state-added questions. More than 400,000 adult interviews are conducted annually. The BRFSS is the sole source of state-level health risk factors, behaviors and prevalence of certain chronic conditions.

Beginning with data collected in 2011, two significant changes have been made to the methodology used with the BRFSS survey. Cell phone interviews are now included, and a new weighting procedure has been implemented. These changes were brought about to maintain the accuracy and validity of the BRFSS. Use of the new methodology will result in prevalence estimates that will be different from estimates achieved with the previous post-stratification procedure. These differences will vary by survey question and state, with the results determined by state variations in demographic variables used for raking plus the proportion of respondents who use cell phones. The CDC has determined that some of the BRFSS indicators will increase for the majority of the states. This increase is most likely due to the addition of cell phone respondents and the new raking method and is not a “real” change in the prevalence from 2010.

(Source: Indiana State Department of Health, Indiana Epidemiology Newsletter. Volume 20, Issue 4, July/August 2012)

**Infant Mortality** is deaths in children under the age of 1 year.

**Low Birth Weight** is an infant weighing less than 2,500 grams (5 pounds, 8 ounces) at birth.

**Reliability of Rates** refers to some of the rates shown in this report, which are based on small populations, a small number of deaths, or both. The rates based on small numbers may be unstable due to random chance factors and should be used with caution. Rates for counties with small populations also may vary considerably from year to year. In addition, allowances must be made for differences in age distributions, etc., when rates are not age-adjusted.

**Very Low Birth Weight** is an infant weighing less than 1,500 grams (3 pounds, 3 ounces) at birth.

### **Recommendations/ Action Strategies 2014**

Through the Interagency Council on Black & Minority Health we hope that this report will inform you of the current state of 16% of Indiana's population's health status is. The Indiana legislature has the authority to establish legislative policies that direct state officials to find ways to ensure equal access to financial coverage of health care services for all Indiana residents irrespective of employment, income, or health status. Also to establish, through legislative mandates, statewide policies that direct state and local public officials to ensure health equity in treatment or organize set standards such as addressing issues of nutrition in their cafeteria and vending machines by providing nutritious alternative food supply, or ensuring infant mortality to be eliminated and Indiana ensures all mothers have safe pregnancy, and children have healthy productive lives. Below you will find the recommendations for 2014.

1. Conduct an exploratory study on why cancer has become the number one cause of death for African Americans surpassing Heart Disease.
2. Develop and employ an education and awareness campaign targeting neighborhoods and communities where there are large clusters of African Americans that are residents.
3. Increase opportunities for Black or African American persons to learn more about cancer, its risk factors, and the importance and methods of early detection through culturally appropriate promotional, educational, and community campaigns.
4. Support efforts to standardize collection and reporting of race, ethnicity and language data, as well as provide accurate and quality data on all populations in Indiana.
5. Increase funding for the Behavioral Risk Factor Surveillance System (BRFSS) to over-sample and increase the number of completed informational and data surveys obtained from Black or African American, Hispanic or Latino, and other high risk racial and ethnic minority communities.
6. Promote among Indiana's health care professionals the use of the U.S. Preventive Services Task Force (USPSTF) guidelines for cancer screenings, diagnosis, and management advanced by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).
7. Establish a statewide surveillance system within racial and ethnic minority populations for tracking asthma death, illness, disability, and impact of occupational and environmental factors on asthma, access to medical care, and asthma management.
8. Increase opportunities to educate Black or African American adults about the dangers of high blood pressure and its complications (e.g., damage to the heart, blood vessels, brain, kidneys, and eyes), and the behaviors that the increase risk for high blood pressure (e.g., cigarette smoking, obesity,

- physical inactivity, high dietary fat and sodium, excessive alcohol consumption, etc.).
9. Partner with the Indiana University School of Optometry, the Indiana Optometric Association, and Prevent Blindness Indiana to promote annual eye examinations through local churches, community health centers, and minority health coalitions.
  10. Create and maintain a chronic disease registry system that collects chronic disease related data to measure and assess the health status of Indiana's Black or African American, Hispanic or Latino, and other high risk racial and ethnic minority populations.
  11. Establish a statewide surveillance system within racial and ethnic minority populations for tracking asthma death, illness, disability, and impact of occupational and environmental factors on asthma, access to medical care, and asthma management.
  12. Create effective and coordinated operational linkages between services available to Black or African American females (e.g., Women, Infants, and Children (WIC) programs, community health centers, minority health coalitions, Prenatal Substance Abuse Prevention Programs (PSUPP) (if needed), tobacco cessation programs (if needed), local Medicaid offices, and community nutrition
  13. Data Collection on a broader segment of minorities including Native Americans. This data collection could/should include data that is already being collected from all the IMHC sponsored agencies. Most if not all of the IMHC groups collect data on various topics and groups that do not do anything with the information. Also, the newly formed CADI group has a committee that is called Data and Surveillance Committee.
  14. This committee is looking to come up with a standardized form that would allow the data collected from the IMHC organizations as well as other groups to be submitted and analyzed by CADI on a state level as part of their state driven requirements.
  15. Addressing social determinates of health as a guiding principal for future legislation. Again, IMHC has given their funded agencies training on this specific topic and all were required to include aspects of it into their programs. There are programs in the market place that can tell you how a child will live their life and what kind of health disparities they will encounter based on their race, where they live and parent's income and life style.
  16. Promote funding for education, early intervention, screening and prevention programs that target disease-specific conditions. It is a known fact that minorities suffer greater percentages by race in all of the major chronic diseases. Funding for these items could have a great impact on the lives of minorities living in Indiana.
  17. Address data rules in regards to utilizing data that does not exceed the mandatory 20 people to be statistically sound. In Indiana your state agencies utilize data that includes just that information that includes one race. i

## **Conclusion**

Indiana has shown progress or trending improvement in many areas yet there are still obstacles to overcome in order to achieve the goal of health equity. While some may assume that health disparities will improve over time without specific intervention, the fact remains that minority populations face an uphill battle in Indiana. It is a gap that will continue to widen, not narrow, as Indiana's citizenry reflects more, not less, global perspective in thought and in populace. Indiana's social determinants of health require considerable attention to the areas of educational attainment, income, poverty, employment and healthcare access in order to achieve success in the aforementioned health objectives. Working toward significant improvement in Indiana's health status will require sustained action --coordinated efforts requiring investments of time, money and energy.

Deliberate planning and implementation will build upon each success with determination that all citizens, regardless of race, national origin, income or age, deserve and will have access to quality health services that ultimately will improve health outcomes. It takes a village to achieve change in any human condition. In the arena of health equity, that village consists of individual citizens, community groups, non-profit and for-profit organizations at the local, county and state levels, all working collaboratively with government agencies and our General Assembly... for the beneficence of all.

### **Year-end Review**

In 2012, IAC examined and recommended preventive measures concerning growing health disparities. For 2013, we wanted to highlight the council affiliates and members and let you know what each organization was doing towards improving health equity for the state. The following are the agency profiles that are connected to minority health initiatives in which IAC and member agencies sponsored and/or supported during 2013.

## **Interagency Council**

### **Agency Report**

**Name:** Lynne Griffin

**Organization:** American Heart Association

#### **Purpose/Mission**

##### **2013 Objectives:**

- Enroll 350 African Americans within Indiana into the “Check, Change, Control” Hypertension program. Participants will monitor their blood pressure a minimum of 2 times per month for 4 consecutive months. Participants also receive monthly health educational sessions on cardiovascular disease, nutrition and diet, fitness, obesity and hypertension
- Reach 2,300 minorities with healthy eating/obesity education and activities
- Most Powerful Voices Gospel Concert stroke education outreach inclusive of stroke education

##### **2013 Objectives Achieved:**

- 354 African Americans enrolled in the “Check, Change, Control” Hypertension program
- 2,900 minorities with healthy eating/obesity education and activities
- MPV concert reached and educated 1,000 African Americans

#### **How can your organization help in furthering health equity**

Heart and Stroke education and outreach within the African American, Hispanic/Latino and Native American communities. Outreach is inclusive of Healthy environments (obesity, sweetened beverage campaigns, food deserts, teaching gardens, walking trails and fitness); hypertension education, screenings and programs; American Heart Association is also an active and participating member of the Heart Health Indiana initiative. American Heart Association can serve as a resource for cardiovascular statistics and medical research initiative. Additionally, American Heart Association offers small Community Health Grants to local organizations that promote and encourage healthy lifestyles, cardiovascular disease education and activities as well as system change to promote healthier environments. Grants are offered on an annual basis

Through collaborations with local and statewide curriculum systems, (health, Science Technology Engineering Math, etc.) we have enhanced opportunities for underserved student populations from middle schools through secondary education. ISDH/OMH was able to increase community involvement recruiting students within regional counties. (Please refer to appendix B for detailed listing of organizations and description of collaborations with community entities)



## **Interagency Council**

### **Agency Report**

**Name:** Teri L. Cardwell

**Organization:** American Indian Center of Indiana Minority Health Coalition appointee

**Purpose/Mission:**

“The American Indian Center of Indiana (AICI) Inc. promotes the empowerment of American Indians/Alaska Natives and Native Hawaiians in Indiana to achieve personal, social, cultural, and economic growth that enhances their quality of life; also, AICI promotes the strengthening of mutual understanding and respect among Indian and non-Indian people in Indiana. In striving to accomplish this, AICI provides culturally appropriate and high-quality workforce development, health outreach, and cultural education services.”

**2013 Objectives:**

- 1) Provide general education throughout the state of Indiana about health and behavioral health conditions that occur at a higher rate among Native Americans.
- 2) Partner with organizations such as IMHC, ISDH, and state universities to conduct research that will add to the body of knowledge about the state of Native health in Indiana.
- 3) Advocate for inclusion of “Native American” as one of the race categories for data collection.

**2013 Objectives Achieved:**

- 1) AICI provided education throughout the state to Native Americans and the general public about health disparities.
- 2) AICI offered health screening for diabetes and hypertension provided by trained health professionals at venues, such as powwows, throughout the state where Native Americans gather.
- 3) In collaboration with IMHC, IUPUI School of Nursing, Ball State University and the Indiana State Department of Health, AICI has engaged in three major community research studies.
- 4) Staff and board members at AICI have advocated for inclusion of Native American as a race for data collection purposes, specifically as it relates to health disparities, mortality rates, and medical diagnoses of concern.
- 5) AICI has continued to advocate for better access to Indian Health Services (IHS) for tribal enrolled Native Americans in the state of Indiana. Because Indiana has no federally recognized tribes, few dedicated services are available outside of employment and education support programs at AICI. A step in the right direction is the recent federal announcement of collaboration between Veterans’ Administration hospitals and the IHS on behalf of Native American veterans.

**How can your organization help in furthering health equity:**

AICI will continue to forge partnerships with organizations and universities that can further inform not only Native Americans about health disparities, but also the general public, state government agencies, and elected officials. We expect to continue to seek opportunities to improve health literacy among Native Americans by offering health screenings. Education of health professionals and social service agencies is also another way that we can contribute to improved health equity through better identification of health concerns specific to Native Americans. AICI anticipates continuing to pursue additional funding that will allow us to expand our efforts to provide improved access to care through health education to the general public, health professionals, and the Native American population; participation in research studies to add to the body of knowledge about Native American health; and, health promotion among Native Americans.

## **Interagency Council**

### **Agency Report**

**Name:** Lynn Smith, Bureau Chief

Critical Populations

**Organization:** Indiana Division of Mental Health and Addiction

**Purpose/Mission:** To ensure that Indiana citizens have access to quality mental health and addiction services that promotes individual, family and community resiliency and recovery.

#### **2013 Objectives:**

1. To promote mental health and addiction prevention for all Hoosiers including suicide prevention, mental health wellness, and substance abuse prevention.
2. To improve access to activities which support individual recovery as related to mental illness and addictions.
3. To improve access to safe and affordable housing for persons with mental illness and addictions.
4. To improve access to primary and behavioral healthcare for persons with mental illness and addictions through identification of evidence based models which integrate healthcare services.

#### **2013 Objectives Achieved:**

1. Expanded prevention activities across the state to persons of all ages using evidence based prevention models.
2. Identified the recovery supports which individuals with mental illness and/or addiction find most effective in their recovery process.
3. Identified gaps in housing availability for persons with mental illness and addiction and began working on development of a strategic plan to address housing.
4. Identified evidence based models for integrated primary and behavioral healthcare and promoted integration initiatives with community mental health centers.

**How can your organization help in furthering health equity:** We will continue to seek partnerships with state agencies, community organizations and concern persons to address health, mental health and addiction issues.

## **Interagency Council**

### **Agency Report**

**Name:** Jose M. Perez

**Organization:** Indiana Health Centers, Inc.

**Purpose/Mission:** To engage exclusively in charitable and educational programs and activities by improving the health status of the community at large with special emphasis on those who, because of their poverty or location in rural areas, have health needs which are not properly addressed.

**2013 Objectives:** To improve the health of the population with chronic conditions. The three that we are concentrating on for PCMH are hypertension, diabetes, and asthma. The three preventive care services are colorectal cancer screening, mammograms, pap smears.

**2013 Objectives Achieved:** Improvements are being tracked through our electronic health records and our quality scores.

**How can your organization help in furthering health equity:** Our mission is to provide primary health care to those at risk in the communities that we serve. We can improve health outcomes by working toward common health goals established for minority and at-risk patients.

## Interagency Council

### Agency Report

**Name:** Calvin Roberson Jr, MHA, MPH

**Organization:** Indiana Minority Health Coalition, Inc.

**Purpose/Mission:**

The Indiana Minority Health Coalition (IMHC), Inc. is a statewide non-profit organization. It is also an Indiana certified Minority Business Enterprise (MBE). IMHC exists to eliminate health disparities through research, education, advocacy, and access to health care services for minority populations.

**2013 Objectives and Achievements:**

- Objective 1: Review, approve, and fund no less than 10 county or multi-county minority health improvement plans developed by local community based organizations. The targeted health priorities included in these health improvement plans focused one or more of the following: chronic disease, environmental health, immunizations, mental health, obesity, oral health, sexually transmitted disease, tobacco prevention and cessation, and vision health.
  - *Achievement 1: IMHC reviewed, approved, and funded 24 county or multi-county minority health improvement plans developed by local community based organizations.*

**Advocacy:**

- Objective 2: Represent minority health interests on standing groups at state and regional levels of focus.
  - *Achievement 2a: IMHC has participated in 85 standing groups to advocate for minority health and promote culturally and linguistically programs and services.*
  - *Achievement 2b: IMHC grantees participated in 257 standing groups to advocate for minority health and promote cultural and linguistically programs and services; for which there were 74,464 encounters resulting from these activities.*
- Objective 3: Support access to services by funding local entities to provide interpretation/translation services and health insurance enrollment to disparate populations.
  - *Achievement 3a: 14 of 24 entities provided interpretation/translation services reaching 808 individuals.*
  - *Achievement 3b: 9 of 24 entities provided enrollment services reaching 202 individuals.*
- Objective 4: Educate policymakers on the issues encountered by minority constituents and the impact of proposed and current policies on those minority populations being served.
  - *Achievement 4a: 19 of 24 entities provided education to policymakers on a wide variety of health policies resulting in 2,557 encounters.*
  - *Achievement 4b: IMHC provided education to policymakers on the following issues during the Indiana General Assembly:*

## **Interim Study Committee Activity, Health Finance Commission Issues**

- HIP updates:
  - HIP extension and federal negotiations-
  - Medicaid waivers
  - A&D (Aged and Disabled) Waiver- -
  - TBI (Traumatic Brain Injury) Waiver- -
  - FSW (Family Supports Waiver)-
  - CIH (Community Integration and Habilitation) Waiver-
  - The establishment and implementation of a health insurance exchange
  - The definition of essential health benefits for Indiana
- 
- Medicaid fraud
    - Review of Medicaid fraud consumer investigation procedures
    - Medicaid false claims and whistleblower protection
  
  - Ambulatory outpatient surgical centers issues
  
  - Certified Registered Nurse Anesthetists as Advanced Practice Nurses
  
  - The collection, maintenance, sharing, and use of electronic health data
    - Mr. Tony Gillespie, Indiana Minority Health Coalition, commended the work that has occurred in Indiana on implementing the use of electronic medical records and discussed some challenges that exist in the implementation. Mr. Gillespie stated that electronic medical records are sometimes disconnected information silos that create barriers in achieving a continuum of care. Mr. Gillespie discussed the following: (1) that providers are required to enter information into multiple systems; (2) the need for collecting prescription information in one location; and (3) the privacy rights of patients. Mr. Gillespie also commented on the benefits of electronic health records, including access to accurate and complete health information. Mr. Gillespie also discussed the importance of streamlining processes, such as the Prior Authorization system into one form, so that it will work with the new electronic systems and reduce barriers to care for patients.
  
  - Traumatic brain injury issues; Update on release of recipient personal information, FSSA; Immunizations; Use of tanning beds; The disposal of used prescription drugs; Medicaid Update from Medicaid Managed Care Organizations; Follow up testimony on free and reduced lunch program; and Co-Pay Issue

## Commission on Mental Health and Addiction

- The Commission will hear testimony on the issue of prescription drug abuse, including issues concerning:
  - Treatment and recovery from prescription drug use addiction.
  - Use of the Indiana Health Care Professional Recruitment and Retention fund to provide loan repayment for student loans incurred by addiction professionals.
  - Criteria for Medicaid reimbursement for detoxification and rehabilitation services for addiction treatment.
  - Best practice treatment for pregnant mothers and newborns with prescription pain medication dependencies and addictions.

## Education and Awareness:

- Objective 5: -Ensure that at least 48 comprehensive, evidence-base health program/interventions are conducted within the targeted health priority areas by June 30, 2013.
  - *Achievement 5a: There were 101 comprehensive, evidence-based health program/interventions conducted that reached 1,751 individuals.*
- Objective 6: Ensure that at least 96 health fairs in total are conducted in the targeted health service areas by June 30, 2013.
  - *Achievement 6a: There were 430 health fairs in total that were conducted in the targeted health services areas that reached 53,710 individuals.*
- Objective 7: Ensure that all grantees are engaged in providing at least one other education and awareness activity that included one or more the following: health presentations, health screenings, printed health communications, and health outreach activities in accordance with their work plans by June 30, 2013.
  - *Achievement 7a: There were 955 health presentations performed that reached 15,372 individuals.*
  - *Achievement 7b: There were 426 health screenings conducted that reached 12,312 individuals.*
  - *Achievement 7c: There were 722 health outreach activities conducted that reached 9,978 individuals.*

## Technical Assistance and Capacity Building

- Objective 8: Provide technical assistance, professional development and/or training to all grantees to improve their skills and ability to work well within their coalition, community, and diverse populations.
  - *Achievement 8a: IMHC provided 3 trainings in board development that primarily targeted its minority health initiative grantees that reached 22 individuals.*

- *Achievement 8b: IMHC provided 13 trainings in cultural competency to a variety of agencies in health care, juvenile justice, child welfare, and social services that reached approximately 550 individuals.*
- Objective 9: Ensure that all grantees match the funding they received by at least 10% by June 30, 2013.
  - *Achievement 9a: IMHC grantees collectively matched the funds they received in excess of 96%. These matching funds comprised of monetary donations, grants, equipment and supply contributions, and in-kind support.*

**How can your organization help in furthering health equity:**

- IMHC plans on continuing to strive to reach health parity through advocacy, education, training, research, and providing access to healthcare services with a special emphasis on disparate populations in general and racial/ethnic minorities specifically.



## **Interagency Council**

### **Agency Report**

**Name:** James E. Garrett Jr., Executive Director

**Organization:** Indiana Commission on the Social Status of Black Males

**Purpose/Mission:** The mission of the Indiana Commission on the Social Status of Black Males is to study the social conditions of the state's black male population, develop strategies to remedy or assist in remedying serious adversities, and make recommendations to improve the educational, social, economic, employment, and other circumstances for Hoosiers. The Indiana Commission on the Social Status of Black Males (ICSSBM) is committed to helping improve the quality of life of Black males throughout the state since its inception in 1993.

**2013 Objectives:** In 2013 the Commission on the Social Status of Black Males will seek to enhance its statewide presence through partnerships with the other cultural commissions, video and public service announcement and local commissions and community partners.

**CHALLENGE 1: Health Initiative to empower Black males to better understand diabetes and hypertension and manage their health from a preventative perspective rather than by crisis.**

**OBJECTIVE 1: Indiana Black Barbershop Health Initiative**

**CHALLENGE 2: Fatherhood and the importance of Dads in order to be better fathers and more effective parents**

**OBJECTIVE 2: Statewide Dad's Expo**

**CHALLENGE 3: Engaging Black Males to Embrace Education and Leadership Skills**

**OBJECTIVE 3: Youth Empowerment Summits or Regional Conferences**

**CHALLENGE 4: Civic Education for Black Males**

**OBJECTIVE 4: Statewide Black Male Youth Day at the Statehouse**

**CHALLENGE 5: Youth Annual HIV/Aids Statewide Awareness**

**OBJECTIVE 5: Annual Statewide HIV/Aids Awareness Program**

**2013 Objectives Achieved:** Indiana Black Barbershop Health Initiative; the one-day event started in Indiana in 2011 the number of health screenings has jumped from 600 in the first year

to 1085 for year three. Initially, six cities participated and for 2013 the total was twelve cities and over fifty barbershops.

Indiana Dad's Expo 2013; More than 100 fathers and other guests gathered on June 8, 2013 for the third annual Dads Expo, a celebration of the vital contribution that fathers make to their children's lives. One of the overarching goals of the expo is to facilitate collaboration beyond the expo itself with all the partners and contributing partners.

Youth Empowerment Summit; the Kings Feast Symposium, Saturday, September 21, 2013, Indiana Government Center-Auditorium focused on young men between the ages of 13-18. The young men were engaged in workshops on Professionalism, Potential, Priorities, and Peer Pressure. Over 50 young men and their parent or guardian attended the all day Symposium.

Statewide Black Male Youth Day at the Statehouse; event planning is in progress for this event to occur in early 2014, possibly during February Black History Month.

Annual Statewide HIV/Aids Awareness Program; is scheduled to occur on Thursday November 7, 2013 to be held at Crispus Attucks Medical Magnet school.

**How can your organization help in furthering health equity:** By seeking to enhance health information and prevention through partnerships with the other cultural commissions, video and public service announcement and local commissions and community partners.

## **Interagency Council**

### **Agency Report**

#### **Name:**

Indiana State Department of Health

#### **Organization:**

Office of Minority Health (IN-OMH)

#### **Purpose/Mission:**

To improve the health of all racial and ethnic populations in Indiana through increased awareness, partnerships, and the development and promotion of effective health policies and programs that help to reduce minority health disparities.

#### **2013 Objectives/Objectives Achieved:**

##### *Annual Minority Health Conference*

*What You Don't Know, Can Kill You!* Minority Health Conference is the first of its kind in Indiana. The purpose is to educate, empower, and equip those individuals who serve minority communities or are a part of minority communities of public health issues that are not necessarily mainstream, but are important to community wellness and health. Two-thousand and thirteen marks its 5<sup>th</sup> year of existence. This conference was sponsored by the ISDH-OMH and its Minority Health Partners. There were two tracks this year, a youth track and a regular track. Our focus was Infant Mortality, Healthy Living, Mental Health, and Smoking Cessation.

##### Minority Health Partners

In order for the ISDH-OMH to be most effective, the office strongly relies on its ties and partnerships with national, state, and local organizations. We are fortunate to have over 40 strong and supportive partnerships with many local, state, and national organizations. For example, we are a proud member of the National Association of State Offices of Minority Health. ISDH-OMH partners consist of local, state, and national partners. We also participate on the Region V Regional Health Equity Council.

##### INShape Indiana Black & Minority Health Fair

Each July, ISDH-OMH sponsors the INShape Indiana Black and Minority Health Fair, which provides free health screenings, education, resources, and consultations valued at \$1,000.00 per participant, during Indiana Black Expo's Summer Celebration. The core goal of the health fair is to increase minority awareness of chronic diseases, and how to prevent them. Increasing minority awareness of diseases, such as diabetes, heart disease, obesity, infant mortality, smoking cessation, hypertension, and cancer is not just the goal of the Office of Minority Health or of the Health Fair. This year we saw over 23,000 attendees.

### *To Sweet for Your Own Good*

Is a Diabetes Initiative that takes place in Marion County and Lake County. It is an all day conference where we along with national, state, and local partners, educate, empower, and equip diabetics, their care givers, and those interested in learning about the disease information regarding Diabetes Management. ISDH-OMH was instrumental getting Lake County started in 2008

### *Latino Expo*

The Indiana Latino Expo is a not for profit organization dedicated to highlighting our values in this community, such as Family, Passion, Collaboration and Preservation of the Latino Culture. OMH sits on the planning committee for the health section of the event. This was our second year helping planning and participating in the event.

### *State Master Research Plan*

Mission: Establish a consortium of key researchers to better understand and address the health disparities.

Vision: Existence of a strong epidemiological research network to support efforts to eliminate health disparities. We partner with FSSA, IMHC, Universities, Hospitals, and other research entities.

### *EMPOWERED Project*

ISDH-OMH just recently received funding for \$150,000.00 for the State Partnership Grant. Its focus is to improve access to health care for racial and ethnic minorities in Indiana. ISDH-OMH was one of the 22 states that was awarded out of 47 states. The grant is awarded from the Department of Health and Human Services (DHHS-OMH). This is our 3rd term of award grant series from DHHS-OMH. After 8 plus years, our objective continues to be through the Enhancing Minority Partnership Opportunities; Working to Eliminate Racial and Ethnic Disparities (EMPOWERED) project. The State Partnership Grant is for 2013-2015. There were 47 awards.

### *Minority Health Month*

In an effort to reduce health disparities and improve the health status of Minority populations, the 107th Congress, in H. Con. Res. 388 agreed on October 3, 2002 to establish a National Minority Health and Health Disparities Month. Many states and organizations are celebrating National Minority Health and Health Disparities Month in April. National Minority Health and Health Disparities Month is raising the awareness surrounding minority health issues. Indiana Minority Health Month is a state level version of the National Minority Health Month.

### *Cultural Competency*

IN-OMH offers employees of the Indiana State Department of Health, and outside partners, cultural competency in health training. The IN-OMH follows, and recommends to all partnering agencies, the same cultural competency guidelines used by the National Office of Minority Health, American Medical Association, American Nursing Association, American Association of

Pediatrics, and the American Psychological Association. The goal of IN-OMH's cultural competency training service is that 80% of program participants will demonstrate increased knowledge of cultural differences among minority populations and will indicate intent to apply cultural competency skills and knowledge in their professional capacity, within one year of completing the competency training. Thus far for 2013 we have had 4 cultural competency training. There will be two opportunities at ISDH. October 28 and December 16.

**How can your organization help in furthering health equity:**

What IN-OMH Does:

- Coordinates, facilitates, and monitors community-based programs tailored to meet the needs of these populations;
- Ensures that health related issues become part of the agendas of outside programs as they relate to underserved populations; and
- Maintains open dialogue with outside agencies in an effort to keep abreast of concerns, trends and problems as seen by these agencies which will assist in identifying gaps, barriers and duplication in services.

With this focus OMH can adequately serve as an expert and assist in pushing health equity throughout the state.